Facts and Updates

Frequently Asked Questions Concerning Beneficiaries of Vermont's Pharmacy Benefit Programs and Part D Plans

Q: What if your customer does not know which Part D Plan he or she has?

- Submit an E1 transaction. It will have the most current information, as well as provide the plan's BIN and PCN numbers and the member's plan-assigned subscriber I.D. number, all of which will be required to process the claim. A list of all of the Part D Plans and their phone numbers can be found on the website of the Office of Vermont Health Access: http://www.ovha.state.vt.us/ProviderPharmacyServices.cfm.
- If no E1 response, call Medicare at 1-866-835-7595 Monday through Friday, 8:00 a.m. to 8:00 p.m. to identify Part D Plan. Another option is to call 1-800-Medicare.

Q: What if the member does not have a Part D Plan?

A: First you should determine if the member is a full-benefit dual eligible or a VPharm member. An easy way to do this is to ask the member if he or she pays a monthly premium to the State of Vermont. If the member does not pay a premium, then the member is a probably a full-benefit dual. If the member does pay a monthly premium, then the member probably has VPharm coverage.

Once you have determined the member's coverage, see below for additional steps:

- **Full-benefit dual eligibles** can have their claims processed through Wellpoint. In addition to processing the claims, this will also trigger an auto-enrollment into a Part D Plan. If the member does not want to be auto-enrolled, he or she can contact the State Health Insurance and Assistance Program (SHIP) at 1-800-642-5119 for assistance in choosing a Part D Plan.

  Wellpoint Billing Information: **BIN#**: 610575 **PCN#**: CMSDUAL01

- **VPharm members** who do not have a Part D Plan should contact the State Health Insurance and Assistance Program (SHIP) at 1-800-642-5119 for assistance in choosing a Part D Plan. Try to submit the claim to VTM to see if it processes. If it does not process, the VPharm member may have been assigned to a Part D Plan, but the Part D Plan has not been confirmed by CMS. If this is the case, the pharmacy should refer the customer to Vermont Health Access Member Services at 1-800-250-8427.

Q: Who pays the member's Part D co-payments and Part D excluded drugs?

A: Co-payments may apply to Part D coverage and may apply to state coverage, depending on the member's plan. Coverage for Part D excluded drugs also depends on the member's plan.

- **Full-benefit dual eligibles** are responsible for their co-payments. Part D plans may charge full-benefit dual eligibles co-payments of $1, $2, $3 or $5 for Part D covered drugs. The state may charge full-benefit dual eligibles co-payments of $1, $2 or $3 for the Part D excluded classes of drugs.

- Part D plans may apply co-payments and coinsurance to **VPharm members** for Part D covered drugs. Payment will depend on the member's benefit plan. Payment for Part D excluded drugs will also depend on the member's benefit plan (see attached coverage chart):

  1) VPharm 1 members should not be charged a co-payment for Part D covered drugs. When a Part D Plan applies a co-payment, it should be billed to VPharm. Correct processing of the claim will result in zero liability to the member. VPharm should be billed for Part D excluded drugs.

  2) VPharm 2 and 3 members may have a co-payment for acute-care drugs as their coverage is for maintenance drugs only, therefore VPharm will not pay Part D Plan co-payments for acute-care drugs.

  3) VPharm 2 and 3 pay for non-acute Part D excluded drugs. Further plan limitations apply.

Q: When I bill the Part D Plan, I am getting a message saying that the drug is not covered. Does this mean that the member's State of Vermont coverage will pay for the drug?

A: The State of Vermont will not cover a Part D Plan drug simply because the Part D Plan does not cover the drug in its formulary. Part D Plan formulary issues need to be handled through the Part D Plan's transition plan, prior authorization process and/or appeals process.

If the drug is one of the Part D excluded classes of drugs, it should be billed to the State of Vermont. Coverage of the drug will depend on the member's plan and compliance with the State of Vermont's preferred drug list (see Clinical Criteria on the website of the Office of Vermont Health Access). http://www.ovha.state.vt.us/Preferred_drugs.cfm

Q: How will the Part D Plans' transition processes apply to individuals whose claims have been paid by the state or other payers rather than by the Part D plans in which they are enrolled during early 2006?

A: CMS is aware that many individuals for whom States or other payers were still making payments in the early months of 2006 will now have their claims paid for the first time by the Part D plan in which they are enrolled. Because States or other payers were

paying these claims, these individuals probably have not been notified by their assigned Part D plans that some of their medications were not on plan formularies before the end of the extended transition period on March 31, 2006. CMS expects that plans will treat these individuals as new enrollees, meaning that they will apply their CMS-approved transition processes to those individuals taking non-formulary drugs once States or other payers have turned off their payment systems and are no longer processing claims for those drugs.

Q: What if my customer has a question about his or her appeal rights when coverage for a specific drug has been denied by a Part D Plan?

A: Customers, their prescribing physicians or pharmacists should always call the Part D Plan to obtain coverage of the specific drug, e.g. appeal, exception request. If the issue remains unresolved, they can contact Vermont Health Access Member Services (VHAMS) for assistance concerning coverage, eligibility, exceptions and appeals related to Vermont Medicaid and Vermont Pharmacy Programs. VHAMS will work with Office of Vermont Health Access to resolve issues as necessary.